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Summary of Systemness Measures Meeting

Held on March 29, 2012

HCQCC Expert Panel on Performance Measurement Committee Meeting

May 14, 2012

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Background

In July, 2011, the EPPM issued a *Notice of Intent* for vendors to develop no-cost proposals for "Systemness" Outcome Measures:

- "Systemness" outcome measures = condition-specific outcomes of care
- Effective measures are defined as those that measure the condition from both provider and patient perspective and across sites of care.
- Conditions included in *Notice of Intent:*
  - Low Back Pain
  - Asthma (Pediatric, Adult)
  - Diabetes (Pediatric, Adult)
  - Depression (Pediatric, Adult)
  - Congestive Heart Failure

However, in October 2011 EPPM modified the request from developing **specific measures** to identifying **general measure themes** (e.g. timeliness of pain improvement, work disability)

March 29 Meeting

- MHQP convened a meeting of the organizations that had responded to the EPPMs request.
- The objectives of the meeting were to:
  - Share approaches and findings related to diagnosis-related systemness outcome measures
  - Discuss common and unique themes and identify barriers
  - Discuss next steps

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Conditions by Organization

	Organization				
Priority Condition	NEQCA	Joslin	Partners	Children's	Hampden County
Low Back Pain			■		
Asthma					
Pediatric			■	■	
Adult					■
Diabetes					
Pediatric		■		■	
Adult	■	■			
Depression					
Pediatric				■	
Adult			■		
Congestive Heart Failure	■				

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High Level Synthesis

- NEQA focused on needs of patients and providers
- Joslin focused on defining a system and system characteristics
- Children's Hospital focused on health related outcomes, communication and coordination and patient and family education
- Partners focused specifically on patient reported outcomes

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There Needs to be a Variety of Perspectives for Systemness When Identifying Measure Themes

- **Patient Perspective**: Do patients/families/coworkers have the education, information and support they need?
- **Provider Perspective**: Do providers have what they need to manage patients' care? Who is ultimately accountable? Who manages communication and coordination of care and information?
- **System Perspective**: Does the system have the structures in place to ensure access to the needed information and care, and the desired outcomes? Is there a shared/aligned mission and incentives?

Different diseases have same questions, different answers

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Presenters

- Joslin Diabetes Center (Sanjeev Mehta, MD)
- NEQCA (Michael Cantor, MD)
- Children's Hospital (Andrea Colon)
- Partners HealthCare (James Pfeffer, MD)

Joslin Diabetes Center

Joslin's Approach

- Define "Systemness"
- Present a rationale for a Disease-Independent Characterization

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Caveats to disease-oriented systems

- **Systems can, and will, be different for the same disease**
  - The organizations will necessarily be different
    - The entities themselves: hospital A vs. hospital B
    - The types of entities: urgent care, hospital, pharmacies, laboratory, payers, practices, specialty centers
  - The approach to care delivery will almost certainly be different
    - PCP vs. specialty-oriented
    - Rural vs. urban
- **Different paths for disease management can exist**
  - Roles of providers will be variably defined
    - Who performs preventative screening?
    - Where are laboratory studies performed?
  - Key is that the roles and responsibilities are agreed upon by partners within a system

System characteristics

- Mission
- Governance
- Incentivization
- Health information exchange
- Patient satisfaction

13

NEQCA

NEQCA's Approach

- Convened multidisciplinary meetings for both Diabetes and CHF
- Included one patient with diabetes and one with CHF
- Goal for both was to identify issues that could lead to measures of success that went beyond a single part of the care system

Common Themes for Measurement

- Patient needs: communication, education, support for daily decisions about management of chronic illness. How does system help them with these?
- Providers: communication, collaboration, team support, clarity of role. How does system help achieve these?
- System: Triple Aim goals – how do we measure impact of the system/infrastructure on success of these goals?

Patient Need Themes (NEQCA)

- Access to information: not just big picture but small issues, especially between visits
  - Self-monitoring review with feedback from professionals – can technology be used for this?
  - Access to answers about "minor" issues (e.g. foot pain/numbness)
- Care plan: clear statement of goals and resources if there are questions that is used to communicate by all involved (patient, PCP, endocrinologist, podiatrist, etc)
- Insight into diabetes and why it matters even if they feel fine
- Medication regimen that works and is simple – must fit patients' lifestyle (insulin at night example)

16

Children's Hospital

Children's' Approach

- Formed one team for each condition to identify areas to be measured
- Teams solicited input from parents/caregivers
- Teams solicited input from clinical experts and reviewed internal program metrics
- Teams synthesized above to identify themes and specific measurement areas

Lessons Learned

- Multi-disciplinary perspectives, including those of the family, are critical to development of relevant measures
- For children, measures must be developmentally appropriate
- Measures should reflect outcomes that are amenable to improvement through care and measurement timelines should reflect evidence-based treatment timelines
- Not all measures that are useful may be feasible to collect across large health systems
- Measure development should include risk adjustment

Health-Related Outcomes: Quality of Life Examples

Minimize negative

- Missed school days
- Missed parental work days
- Activity limitations (after school programs, extracurricular activities)
- Level of family conflict
- Perceived burden of disease or condition
- Academic functioning
- Friendships/Spending time with peers

Health-Related Outcomes: Clinical Health Examples

- Pediatric Asthma
  - Asthma control is achieved and maintained
  - ED visits and hospitalizations are minimized
- Pediatric Diabetes
  - Hemoglobin A1c
  - Hospitalization for diabetic ketoacidosis
- Pediatric Depression
  - ED visits are minimized
  - Core measures of depression show improvement (e.g. mood, anhedonia, suicidality, helplessness, self-esteem, guilt)
  - Substance abuse (relevant only to later developmental stages)

Parent and Family Education

- *Clinicians and parent/caregivers*:
  - Parent/caregivers should understand the child's disease-related medical needs
- Examples include:
  - Families and patients understand the child's specific asthma triggers and how to avoid them
  - Families and patients can implement the child's asthma action plan
  - Family members' understanding of diabetes care plan for oversight of diabetes care in settings other than the home environment (e.g. school; afterschool programs; college)
  - Parents and patients are able to access information about diabetes education event in the community and via internet.

Partners Healthcare

Partners' HealthCare's Approach

- Used Patient Reported Outcomes (PROs)
- Team of experts collaborated or were consulted to develop themes
- Patient perspective provided from providers who treat each condition (for low back pain, expert is also a patient)

Project Background

Why they focused on Patient Reported Outcomes (PROs) as aligned with measures of 'systemness'

- By definition, PROs are measures that matter — to patients.
  - Patient's opinion on how they are progressing along various dimensions of their medical condition. Examples:
    - Physical and social activities (e.g., return to work, ability to walk up stairs)
    - Free from Pain
    - Mental health
    - Anxiety or burden of disease
- And they are relatively easy to collect, are:
  - Flexible in data gathering approach (paper, email, in-clinic)
  - Inclusive (simple, translatable, amenable to low level of physical function) and
  - Are collectable and comparable over time and across sites of care.

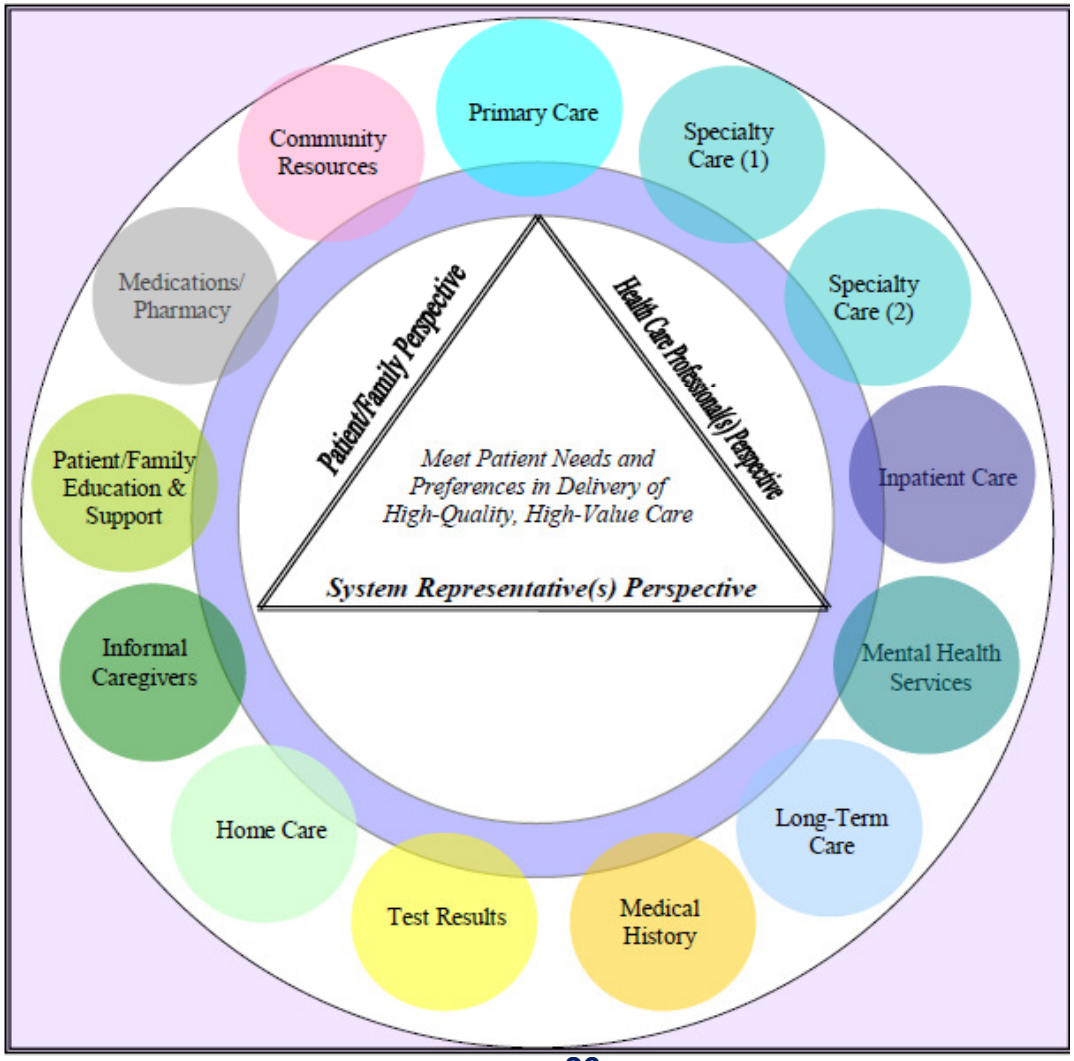
Lessons Learned by Partners

- One size does not fit all…

  For each of the 3 clinical conditions their expert groups used a slightly different process to develop themes.
  - Different tools exist or recommended for use by each condition.
  - Experts recommended themes which may or may not be included in existing or recommended tools.
- Obtaining patient perspective on PRO themes is a challenge:
  - PROs are a new kind of data; patients have to get used to it.

    (However Partners 'early results suggest patients like it; a lot!)
  - Timing: Polling patients on specific PRO questions is best once we move from 'themes' to specific questions.

Conceptual Model *(source: Care Coordination Measures Atlas, AHRQ, December, 2010)*



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Discussion and Next Steps

27

Appendix: Disease Specific Themes

Diabetes Themes (NEQCA)

- Family and caregiver involvement is important
  - Can be difficult – do they attend visits?
  - Very important for patients who are prone to low blood sugar where a trained family member can make a difference
  - Co-workers are also an important source of support, especially for low blood sugar
- Diabetes can be frustrating for PCPs to manage
  - Some reluctant to refer to team members like diabetes educators – do not see their value for them or patients. Should use of team members be an expectation?
  - Patient visits often tense or unsatisfying since patients are not seen as cooperative and visits are often avoided or dreaded – what can be done to improve this?

Diabetes Themes (NEQCA continued)

- Needs and metrics should reflect stage of diabetes
  - Initial diagnosis: comprehensive education that motivates behavior change; team based; community supports
  - Well-controlled: Regular visits; use of teach back to assure patient understanding; outcomes – A1c, no diabetes-related hospitalizations, no diabetes-related complications; team based care
  - Complex (patient with complications): same as well-controlled with addition of team members (PharmD, CDE, specialists, health coaches, care managers) idea is that patient has comprehensive basket of services

Diabetes Themes: Communication and Coordination(CHB)

- Access to a multidisciplinary diabetes care team by patient/family
- Diabetes program offers central scheduling of multidisciplinary care team appointments and coordination of appointments in location and time.
- Frequency of care with diabetes care providers (physician/DNE, nutrition, behavioral/mental health)
- Family members' understanding of diabetes care plan for oversight of diabetes care in settings other than the home environment (e.g. school; afterschool programs; college)
- School orders for school age patients with diabetes signed by clinician and parent by September 30 of each school year.
- Diabetes program has emergency access to the diabetes care team for assistance with diabetes-related emergencies 24 hours per day, 7 days per week.
- PCP receives timely reports of the patient's specialty care/hospitalizations

CHF Themes (NEQCA)

- Systemness means that the system works together so that the patient is better as the result of the care provided
- Outcomes: more related to mortality – different than diabetes
  - Hospice and palliative care important – look at use and transition rates
  - Defining appropriate transition to hospice/palliative care would be helpful
- Patient well-being: functional status and symptoms
  - KC Cardiomyopathy questionnaire is helpful for this

CHF Themes (NEQCA continued)

- Medication issues: need to stratify patients so that interventions can be stratified
  - Must consider psycho-social impact of complex medications – there are burdens to this that go beyond cost
- Readmissions also a potential measure of systemness
  - Role of VNA and SNFs in care of CHF patients important – some projects already underway (STAAR)
  - Evaluate appropriate use of services – ED, hospital, as potential measures of coordination of care

CHF Themes (NEQCA continued)

- Communication: need communication along continuum and this does not happen
  - Keeping docs on same page is difficult – patient keeps own records, has 4 docs and PCP does not oversee all decisions.
  - Challenging for patients with comorbidities – e.g. CHF flare makes glucose control worse
  - Patient calls different doc depending on symptom – wt gain is cardiologist, shortness of breath is pulmonologist
- Who is responsible for care of patient with CHF?
  - Varies between PCP, cardiology, usually depends on PCP
  - Prevents systematic approach to care

Pediatric Asthma Themes: Communication and Coordination (CHB)

- *Parents/caregivers*: Clinicians should be involved in all aspects of the child's care, including treatment by other clinicians
- *Clinicians*: Clinicians want to know or be involved in all aspects of a patient's treatment
- Examples:
  - Child has one asthma care plan shared across all providers
  - The child's medical home is aware of the child's level of functioning outside of the office visit, at school, during activities including organized sports, and at home
  - Communication between acute health care utilization (i.e. Emergency Department) and primary care

Pediatric Asthma Themes (Partners)

- Missed school days
- Participation in activities
- ED visits
- Admissions
- Functional status
- Symptom response plan
- Communication between physician and parent/patient about treatment and expectations.
- Symptom management
- Patient/family anxiety
- Patient/family satisfaction with medical care

Pediatric Depression Themes: Communication & Coordination (CHB)

- *Parents/caregivers*: Clinicians should be involved in all aspects of the child's care, including treatment by other clinicians
- *Clinicians*: Clinicians want to know or be involved in all aspects of a patient's treatment
- Examples:
  - Coordination across all providers (primary, specialty, acute)
  - Input from parents/caregivers, patient and clinicians are combined to create a full picture of functioning across all settings

Adult Depression Themes: Partners

- Reduction in frequency and severity of symptoms
- Communication about patient's functional improvement goals
- Progress toward patient's functional improvement goals
- Functional status
    - Quality of life
    - Well-being
    - Motivation and Interest
    - Relationships/Social functioning
    - Physical: sleep, appetite, health status
    - If on medication, balance in managing symptoms and side effects

Low Back Pain Themes: Partners

- Functional Status
- Pain Intensity
- Mental Status
- Communication between provider and patient regarding expectation for pain improvement. *
- Shared decision making between provider and patient *
- Disability
- Social Functioning

* The PROMIS health questionnaires do not address communication and shared decision making.